Group MedicareBlue℠ Rx
A Medicare Prescription Drug Plan

MEDICARE PRESCRIPTION DRUG PLAN GROUP ENROLLMENT FORM

INSTRUCTIONS: Please complete A through D of this form. Sign and date where indicated. Please read each statement in sections E & F.

A. Personal Information (please print clearly)

Group Name	Group Number
North Dakota Public Employees Retirement System (NDPERS) **MedicareBlue Rx Option E**	**012000**

Last Name	First Name	Middle Initial	☐ Mr. ☐ Mrs. ☐ Ms.

Birth Date: (MM/DD/YYYY) (__/__/____)	☐ Male ☐ Female	Social Security # (optional):	Work Phone #: ( )	Home Phone #: ( )

Permanent Residence Address:
Street: City: State: ZIP Code:

Mailing Address (only if different from your Permanent Residence Address):
Street: City: State: ZIP Code:

B. Medicare Information: Copy information exactly as it appears on your Medicare card

First Name:	Middle Initial:	Last Name:

Medicare Claim (ID) No. (include alpha characters)

Is entitled to: Effective Date (MM-DD-YYYY) (__/__/____) **HOSPITAL (Part A)** _____ Effective Date (MM-DD-YYYY) (__/__/____) **MEDICAL (Part B)** _____

C. Please answer the following questions to help Medicare coordinate your benefits:

Some individuals may have other drug coverage, including other private insurance, TRICARE, Federal employee health benefits coverage, VA benefits or State pharmaceutical assistance programs.

1. Will you have other prescription drug coverage in addition to *Group MedicareBlue Rx*? ☐ Yes ☐ No

If "yes", please list your other coverage and your identification (ID) number(s) for this coverage:

Company Name(s) of other coverage: _____

ID number(s) for this coverage: _____

Group(s) number for this coverage: _____ Effective date of other group Rx coverage: (MM-DD-YYYY) (__/__/____)

2. Are you a resident in a long-term care facility, such as a nursing home? ☐ Yes ☐ No

If "yes" please provide the Name of the Institution: _____

Address (number, street, city and state) and phone number of Institution: _____

D. Please read back of enrollment form and sign below:

I understand that my signature** on this application means that I have read and understand the contents of this application including the information on the back of this form. The information on this enrollment form is correct to the best of my knowledge. I understand that if I intentionally provide false information on this form, I will be disenrolled from the plan.

Applicant or Guardian** Signature _____ Date _____

Guardian Name (Print) _____ Telephone No. _____

**Or that of a person authorized to act on behalf of the individual under the laws of the State where the individual resides. If signed by another individual, the signature certifies that the person is authorized under State law to complete this enrollment and that documentation of this authority is available upon request by *Group MedicareBlue Rx* or by Medicare.

☐ Check if Applicant received assistance in completing this form. The person who assisted Applicant must sign below.

Signature _____ Date _____ Relationship to Applicant _____

To be completed by agent

Agent Name (Print) _____ Agent Number _____ Agency Number _____

Agent Signature _____ Date _____ Telephone Number _____

E. STOP - Please Read This Important Information - STOP

If you are a member of a Medicare Advantage Plan (like an HMO or PPO), you may already have a prescription drug benefit from your Medicare Advantage plan that will meet your needs. By joining *Group MedicareBlue Rx*, your membership in your Medicare Advantage plan may end. This will affect both your doctor and hospital coverage as well as your prescription drug benefits. Read the information that your Medicare Advantage plan sends you and if you have questions, contact your Medicare Advantage plan.

F. Enrollment Authorization:

Please read carefully. Sign the front page after reading all statements in this section. Keep the copy marked "applicant" for your records.

1. I understand *Group MedicareBlue Rx* is a Medicare Prescription Drug Plan with a Medicare contract. *Group MedicareBlue Rx* coverage is provided by only one of the following plans, Wellmark Blue Cross and Blue Shield of Iowa,* Blue Cross and Blue Shield of Minnesota,* Blue Cross and Blue Shield of Montana,* Blue Cross and Blue Shield of Nebraska,* Blue Cross Blue Shield of North Dakota,* Wellmark Blue Cross and Blue Shield of South Dakota,* and Blue Cross Blue Shield of Wyoming.*
2. I understand *Group MedicareBlue Rx* is a Medicare prescription drug plan and is in addition to my coverage under Medicare; therefore, I will need to keep my Medicare coverage. It is my responsibility to inform *Group MedicareBlue Rx* of any prescription drug coverage that I have or may get in the future. I can only be in one Medicare prescription drug plan at a time. Enrollment in the plan is generally for the entire year.
3. I understand I may **disenroll** from *Group MedicareBlue Rx* only at certain times of the year, or under certain special circumstances, by sending a request to *Group MedicareBlue Rx* or by calling 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048.
4. I understand some group plans are limited to a specific service area. Any move out of this area may affect eligibility. I understand I must check with my group health plan.
5. I understand once I am a member of *Group MedicareBlue Rx*, I have **the right to appeal *Group MedicareBlue Rx* decisions** about payment or services if I disagree. I will read the Evidence of Coverage document from *Group MedicareBlue Rx* when I receive it to know the rules I must follow in order to receive coverage with this Medicare drug plan. I understand that *Group MedicareBlue Rx* will send me final approval of my enrollment in the plan.
6. I understand that I should not disenroll from any Medicare supplement plan, or Medigap or Medicare Select plan until I get that approval from *Group MedicareBlue Rx*.
7. I understand by joining this Medicare Prescription drug plan, I acknowledge that *Group MedicareBlue Rx* will release my information to Medicare and other plans as is necessary for treatment, payment and health care operations.
8. I understand that if I obtain prescriptions outside the *Group MedicareBlue Rx* network, I will be subject to out-of-network copayments or coinsurances.
9. I understand that if I am working with an agent who is either employed by or contracted with the independent Blue Cross and Blue Shield plans offering *Group Medicare Blue Rx* the person may be compensated based on my enrollment plan.

*Independent licensees of the Blue Cross and Blue Shield Association.

Distribution: White Copy: Carrier
Yellow Copy: Applicant
Pink Copy: Broker